



APPLICATION - Adolescent Life Care Program

Thank you for your interest in Minnesota Teen Challenge. Our program is designed to help teenagers who are struggling with drugs, alcohol, emotional instability and delinquent behaviors and desire a Christian faith-based approach to recovery.

Please complete the enclosed application and other documents and return to:

Minnesota Teen Challenge
Attention: Admissions Department
1619 Portland Ave South
Minneapolis, MN 55404

Phone: (612) 238-6500
Fax: (612) 823-4913

Upon receipt of your application, an admissions representative will contact you and begin processing your application. The length of the application process can vary from a couple of days to two weeks. In processing applications a number of things are taken into consideration including: mental health, medical condition, past and present legal status, funding eligibility, and level of care required.

MnTC is a voluntary program. Please carefully review all of the information in this packet to determine if our program is right for your child. If not, please contact our admissions office to request a referral list of other programs.

It's important that your contact information is current. If you are submitting an application and have relocated please be sure to notify our admissions department of your current contact information.

Important Applicant Information:

- § Copies of child custody paperwork is required if there is an existing custody agreement.
- § Applicants requiring detoxification must do so prior to entry.
- § Applicants are strongly encouraged to enter the program with at least a 30 day supply of all currently prescribed medications (with the exclusion of prescribed narcotics).
- § A physical examination is required prior to admission. Some applicants may be approved for admission prior to having a physical examination, provided they agree to have a physical immediately upon entering our program. Tests for HIV, STD's, Tuberculosis and Hepatitis are required as part of the physical exam. Students who enter the program without having a physical and those who do not have medical insurance will be charged \$5 for a Tuberculosis test upon admission into the program.

Thank you again for your interest in our program. We understand that this is a big decision for parents to make. Please do not hesitate to contact an admission representative to get more information about our program. We look forward to the opportunity to help your child gain freedom from life controlling problems.

Please return only the application and following associated forms to the admissions office. The Program Policies and General Information are for your records.



APPLICATION - Adolescent Life Care Program

First Name: _____
Middle Name: _____
Last Name: _____

SSN: _____ - _____ - _____
DOB: ____/____/____ Age: _____

Sex:
[] Male
[] Female

Current Address:

Street: _____
City: _____
State: _____ Zip: _____
Phone: _____ Email: _____

Height: _____ Weight: _____

Legal Resident Of:

State: _____
County: _____

Does Your Child Have Any Relatives Or Friends Currently In Our Program? [] Yes [] No

Has Your Child Previously Been In Our Program? [] Yes [] No How Many Years Ago? _____

Custody Status: [] Parents Married [] Joint Legal [] Father- Sole [] Mother-Sole [] Relative _____

Citizenship: [] United States [] Other

Race: [] American Indian [] Asian [] Black [] Hispanic [] Multi Racial [] Other [] White

Is Your Child Currently Enrolled in School? [] Yes [] No What is the grade level? _____

Does Your Child Read And Write English At A 5th Grade Level or Above: [] Yes [] No

Does Your Child Have A High School Diploma? [] Yes [] No If No, Does Your Child Have A GED? [] Yes [] No

My Child Mainly Needs Help With: (Check All That Apply) [] Alcohol Use [] Drug Use [] Other: _____

Does Your Child Use Tobacco? [] Yes [] No (Tobacco use is not permitted at any time while enrolled in the program)

Has Your Child Ever Been Treated For Chemical Addiction/Use? [] Yes [] No How many times? _____

Prior Treatment Facility: (list the most recent treatment program your child has been in)

Name of Facility: _____
Address: _____
City: _____ State: _____ Zip: _____
Dates of Treatment: ____/____/____ to ____/____/____
Reason for Treatment: _____
Did you complete the program? [] Yes [] No

For Admission Use only: [Empty box]

In your own words, tell us why you want your child to come to Minnesota Teen Challenge and the main issues you believe you need to deal with while in the program: (Please print clearly)

[Multiple horizontal lines for handwritten response]



APPLICATION - Adolescent Life Care Program

PHYSICAL HEALTH

Medical History: (Check all that apply to child's current and past conditions)

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Head Trauma/TBI | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> STI/STD |
| | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |

Does your child have any current medical concerns? If yes, please be specific: _____

Is your child currently being treated by a doctor? Yes No

Name of Primary Doctor: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 Dates of Treatment: ____/____/____ to ____/____/____
 Reason for Treatment: _____

For Admission Use Only:

Is your child pregnant? Yes No Due Date: ____/____/____

Is your child allergic to any medications? Yes No If Yes, what medications? _____

Is your child being treated with prescribed narcotics? (Applicants on prescribed narcotics will need to complete the regimen prior to admission or switch to non-narcotic pain medications.) Yes No

If Yes, what medications? _____

Non- Psychiatric Medications:

List all current non-psychiatric medications:

- | | | |
|----------|----------|----------|
| 1. _____ | 4. _____ | 7. _____ |
| 2. _____ | 5. _____ | 8. _____ |
| 3. _____ | 6. _____ | 9. _____ |

Special Needs:

- | | | |
|---|--|-------------|
| Does your child have any type of disability? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Type: _____ |
| Does your child have any chronic conditions? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Type: _____ |
| Does your child have any medical restrictions? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Type: _____ |
| Does your child have any other type of special needs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Type: _____ |
| Does your child have any allergies? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Type: _____ |
| Does your child require a special diet?* | <input type="checkbox"/> Yes <input type="checkbox"/> No | Type: _____ |

*Special dietary accommodations can be made for diabetics only. All others will be required to eat the meals as provided.



APPLICATION - Adolescent Life Care Program

MENTAL HEALTH

Has your child ever been treated for mental disorders? Yes No When: ____/____/____
Has your child ever been treated by a psychiatrist/psychologist? Yes No Last Visit: ____/____/____

Mental Health History: (Check all that apply to your child's current and past conditions)

- | | | |
|---|--|---|
| <input type="checkbox"/> ADD / ADHD | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Physical Abuse |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Hearing Voices | <input type="checkbox"/> Rape |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Homicidal Tendencies/Thoughts | <input type="checkbox"/> Schizoaffective Disorder |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Multiple Personalities | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Paranoia | <input type="checkbox"/> Suicide Attempts |
| <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Personality Disorder | <input type="checkbox"/> Suicide Thoughts |

Has your child thought about, or attempted suicide in the past 3 months? Yes No If yes, how long ago: ____

Name of Primary Psychiatrist/Psychologist: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Dates of Treatment: ____/____/____ to ____/____/____

Reason for Treatment: _____

For Admission Use Only:

Mental Health Medications Currently Taking:

Medication Name	Dosage	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

FINANCIAL INFORMATION (to be used to help determine eligibility for financial assistance)

Does your child receive any other income (SSI, disability, etc)? Yes No If yes, what is the monthly amount? ____

Does your child currently receive any government assistance? Yes No What type? _____

Does your child have medical insurance? Yes No If yes, please provide the following information:

Insurance Provider: _____ Member ID Number: _____

City: _____ State: _____ Zip: _____ Phone: () ____ - _____

Does your child have a case worker? Yes No If yes, please provide the following information:

Case Worker's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

For Admission Use Only:



APPLICATION - Adolescent Life Care Program

LEGAL ISSUES

Is your child currently on probation? [] Yes [] No State/County: _____
Is your child currently on parole? [] Yes [] No State/County: _____
Does your child currently have any court cases pending? [] Yes [] No State/County: _____
Is your child currently under investigation for anything? [] Yes [] No State/County: _____
Does your child currently have any outstanding warrants? [] Yes [] No State/County: _____

Has your child ever been convicted of a violent crime? [] Yes [] No If yes, please list each conviction and date:

Has your child ever been convicted of a sex related crime: [] Yes [] No If yes, please list each conviction and date:

Is your child currently facing charges for a violent or sex related crime? [] Yes [] No If yes, please describe fully:

Is your child required to register as a sexual or predatory offender? [] Yes [] No

Probation Officer's Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

For Admission Use Only: []

Attorney's Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

For Admission Use Only: []

EMERGENCY CONTACTS

Primary Contact Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Alternate Phone: _____ Email: _____

Secondary Contact Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Alternate Phone: _____ Email: _____

By my signature below, I certify that all answers and statements on this application are true and complete to the best of my knowledge. I understand that should an investigation disclose untruthful or misleading answers, my child may be discharged from the Minnesota Teen Challenge program. Furthermore, I understand that Minnesota Teen Challenge is a Christian, faith-based program and that I have made a free and independent choice to enroll my child. I understand that other program options are available to me and have had an opportunity to request a referral.

Please initial indicating that you have received, read, and agree to abide by the following documents:

- Program Policies and General Information
Prohibited Medication
Break Policy
Room and Board Fee Information

Parent's Signature _____ Date ____/____/____

Voluntary Compliance with Faith Based Activities

Minnesota Teen Challenge is a faith-based program that is based upon Christian principles and practices. As such, Minnesota Teen Challenge is only an appropriate option for people desiring such a program and who are willing to commit to fully participate in it. If you do not want to participate in this program and follow the requirements listed below, please contact our admissions department and we will provide a referral list of other programs that may better meet your needs.

No provider of substance abuse services receiving Federal funds from the U.S. Substance Abuse and Mental Health Services administration, including this organization, may discriminate against on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in religious practice. **If you object** to the spiritual education model utilized by Minnesota Teen Challenge and object to the religious character of this organization, Federal law gives you the right to a referral to another provider of substance abuse services. The referral, and your receipt of alternative services, must occur within a reasonable period of time after you request them. The alternative provider must be accessible to you and have the capacity to provide substance abuse services. The services provided to you by the alternative provider must be of a value not less than the value of the services you would have received from this organization.

Please read each item carefully and initial your acceptance to each program requirement.

Upon admittance to Minnesota Teen Challenge, I agree to the following:

- _____ My child will participate in daily devotions, Bible reading, and prayer.
- _____ My child will participate in the Teen Challenge choir which performs Christian songs at weekly church services and special events.
- _____ My child will participate in lecture classes, individualized study courses, group counseling, individual counseling, and other program components that are based on Christian principles.
- _____ My child will attend church services when scheduled.
- _____ If offered the opportunity to partake in communion or water baptism participation is voluntary.
- _____ If I object to the religious nature of this program and its requirements, I will notify the Dean of Students and receive a referral to another program of my choosing.

My signature below indicates that I have carefully considered the Christian nature of the program and have made a free and independent choice to participate in the Minnesota Teen Challenge program. I also acknowledge that I have been given the opportunity to ask for a referral list of other faith-based and secular programs.

I have talked to my child about placing him/her in a faith-based program.

Parent's Signature

____/____/____
Date

Child's Name: _____

Authorization for Release of Confidential Information

Student/Applicant's Full Legal Name: _____
First Middle Last

Birth Date: ____/____/____

I authorize the disclosure of records and information about my child between:

Minnesota Teen Challenge
 1619 Portland Avenue
 Minneapolis, MN 55404
 Phone: (612) 373-3366
 Fax: (612) 333-4111
 Contact Person: _____

Name: _____
 Address: _____
 City, State, Zip: _____
 Phone: (____) _____ - _____
 Fax: (____) _____ - _____
 Contact Person: _____

"At the request of the individual," I authorize the release of the following information:

Disclose to the above party	Obtain from the above party	Items Requested	Disclose to the above party	Obtain from the above party	Items Requested
_____	_____	Progress Review	_____	_____	Medical
_____	_____	Follow-up/Aftercare	_____	_____	Financial
_____	_____	Treatment/Discharge Summary	_____	_____	Social/Collaboration
_____	_____	Educational	_____	_____	Legal Consultation
_____	_____	Employment	_____	_____	Phone Conversation
_____	_____	Psychological	_____	_____	Other (Specify):

I understand that:

1. My health information is protected by Federal Confidentiality Rules (42 CFR Part 2; and/or HIPAA, 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances as outlined in MTC policies. I understand that I have the right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws.
2. I can revoke this authorization in writing at any time by providing a written notification to MTC, except to the extent that action has been taken in reliance on it. This authorization will expire one year from the date I sign, unless I request an earlier revocation in writing.
3. For disclosures other than treatment, payment, and healthcare operations purposes, treatment may not be conditioned on my agreement to sign an authorization, unless I am receiving care solely to create protected health information for disclosure to a third party.
4. Communications resulting from this authorization will reveal that I have received services at Minnesota Teen Challenge.
5. Federal confidentiality regulations prohibit re-disclosure of information.

 Parent/Guardian Signature

 Date

 Staff Signature

 Date

(This page must be returned with the application if you want us to talk to somebody else about your child's enrollment in the program)

SCHOOL RECORD INFORMATION

This form allows the Academy to obtain school records. The Parent or Legal Guardian must fill out the information below concerning the last educational institution of the student to be enrolled and sign the form at the bottom.

To: _____
Name of last school attended

Address of School: _____
Street Address

_____ City State Zip

School Phone Number: (_____) _____ - _____

School Fax Number: (_____) _____ - _____

RE: AUTHORIZATION OF RELEASE OF SCHOOL RECORDS

To Whom It May Concern:

My child, _____, SS# _____, has withdrawn from your school. Please release all transcripts, the **most recent** Special Education evaluation report, IEP, 504 plan and Minnesota Basic Skills test results pertaining to my child immediately. However, **do not send** the contents of my child's complete cumulative folder.

Facsimile copies of these records **must** be sent to the Principal's Office, Challenge Academy **within two business days of receiving this request**, as required by Minnesota Statutes 2001 Supplement, Section 125A.515, Subdivision 5. MTCA's fax number is (612) 333-4111.

I appreciate your assistance. If you have any questions, please contact Challenge Academy at 1619 Portland Avenue South, Minneapolis, MN 55404. Phone: (612) 373-3366.

(Please type or print) Parent or legal guardian name

Parent or legal guardian signature

Date

PARENTAL RELEASE OF LIABILITY AGREEMENT

I/We, _____, parent(s), guardian(s), or conservator(s) of _____, a minor child, born on _____, hereby agree that he/she can enroll in Minnesota Teen Challenge (MnTC) and Minnesota Teen Challenge Academy (MTCA), a faith-based residential rehabilitation program. I/We further agree that I/we relieve MnTC and MTCA, its staff, employees, students, and board members from any responsibility or liability for any damages to him/her or his/her property during his/her residence at MnTC or during any related travel and/or activities. I/We also agree to release, hold harmless, and relinquish all rights to pursue any cause of action whatsoever against MnTC and MTCA, its staff, employees, students, and board members if a student voluntarily leaves MnTC or for any damages incurred during his/her residence. I further acknowledge that MnTC is not a lock down facility and that in the event my child runs away from the facility, MnTC is not responsible for his/her safety and will make no effort to find the child or bring him/her back to the facility.

EMERGENCY MEDICAL, SURGICAL, & DENTAL PERMIT

MnTC may provide emergency services anytime the parent(s), guardian(s), or emergency contact person(s) can not be reached, when, in the opinion of the attending, duly qualified physician, said services are deemed necessary or advisable. I/we consent to the administration of whatever anesthetics are advisable or necessary and I/we agree to be solely responsible for payment of any and all medical or dental services obtained.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

State of _____

County of _____

Subscribed and sworn before me by:

_____ and

On this _____ day of _____, 20____

Notary Public

My commission expires: _____

Minnesota Teen Challenge Physical Examination Form

Student's Name: _____ SSN: _____ - _____ - _____ Date of Birth: ____/____/____

Sex: Male Female Height: _____ Weight: _____ BP _____ Pulse _____

Medications (list all medications the student is currently taking)

Medication	Dose	Indication

Examination				Abnormality description
	Normal	Abnormal	Not done	
Head, eyes, ears, nose, throat				
Neck				
Cardiovascular System				
Respiratory System				
Abdomen				
Skin				
Extremities				
Neurological System				
Mulculoskeletal System				
Rectal				
Urogenital system				

Required lab testing for Minnesota Teen Challenge students

- HIV
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Mantoux
- Pregnancy Test (all females)

***Testing for other STD's at discretion of physician**

Food allergies? Yes No _____

Type of reaction _____

Drug allergies? Yes No _____

Type of reaction _____

Are there any medical conditions that may endanger the health of the staff or students in our residential program?

Yes No Condition: _____

Is there any reason why this applicant should not assist in the preparation of food?

Yes No Condition _____

Physician's Printed Name: _____ Date of Physical Exam: ____/____/____

Physician's Signature: _____ Phone: (____) _____ - _____

I authorize the release of the physical examination information contained on this form and laboratory test results to Minnesota Teen Challenge. I also authorize the physician who performed the physical examination and/or his/her staff to discuss my medical condition with Minnesota Teen Challenge.

Student's Signature: _____ Date: ____/____/____

Please send this completed form and laboratory reports to: _____

Minnesota Teen Challenge
 1619 Portland Ave.
 Minneapolis, MN 55404-1598
 Phone: (612) 373-3366
 Fax: (612) 823-4913

Kids Need Shots for School!

To go to school in Minnesota, students must show they've had these immunizations.

Directions:

- Find the child's age/grade level and read across to the right.
 - Has the child had the number of shots shown by the checkmark(s) under each vaccine?
 - Note: Each row is meant to be read separately, so don't add up the columns of checkmarks under each vaccine.
 - Example: A preschooler needs 4 DTP, then to enter kindergarten he or she needs 1 more DTP, for a total of 5 (not 9).
- *unless a Td (tetanus-diphtheria) was given after the 7th birthday; then it must be repeated 10 years after the last dose.

These are the shots the school law requires.
parents may get a legal exemption from the school law

	DTP Diphtheria, tetanus, pertussis (whooping cough)	Polio (OPV and/or IPV)	MMR measles, mumps, rubella	HiB Haemophilus Influenza type b	Hepatitis B	Varicella (chicken pox)
Preschool	üüüü	üüü	ü	At least ü		ü
Kindergarten (6 years old and younger)	üüüüü 5th shot not needed if 4th was after age 4	üüüüü 4th polio not needed if 3rd was after age 4	üü		üüü	ü
Age 7 through 6th grade	At least üüü	At least üüü	ü			
7th through 12th grade	At least üüü AND one Td or Tdap shot required at age 11 or older	At least üüü	üü		üüü 7th grade only	üüü 7th grade only

For medical reasons or conscientiously held beliefs.

School children also need a shot for varicella (chicken pox), which is not required by the school law.

For more information, call your doctor, clinic, health plan, or the Minnesota Immunization Hotline at 1-800-657-3970

Pupil Health Immunization Record

Name	Student Number
Birth Date	

FOR SCHOOL USE ONLY

Complete; booster required in _____

In process; 18 mo. Expires _____

Medical exemption for _____

Conscientious objection for _____

Minnesota Statutes Section 121A.15 requires that all children who are enrolled in a Minnesota school be immunized against diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, and hepatitis B* allowing for certain specified exceptions (see reverse side). This form is designed to provide the school with information required by the law and will be available for review by the Minnesota Department of Health and the local community health board.

Enter the MONTH, DAY and YEAR for all vaccines the pupil received. DO NOT USE (✓) or (X).

<u>Type of Vaccine</u>	1 st Dose Mo/Day/Yr	2 nd Dose Mo/Day/Yr	3 rd Dose Mo/Day/Yr	4 th Dose Mo/Day/Yr	5 th Dose Mo/Day/Yr
Diphtheria, Tetanus and Pertussis (DtaP, DTP)					
Diphtheria and Tetanus (DT) – pediatric formulation (<7 yrs)					
Tetanus and Diphtheria (TD) – adult formulation (>7 years)					
Polio (IPV, OPV)					
Measles, Mumps, & Rubella (MMR) [minimum age: 12 mos]					
Hepatitis B (HBV)*					
Haemophilus influenzae type b (Hib)**					
Varicella (chickenpox)***					

* HBV will be required for kindergarten enrollees in 2000-01 and both kindergarten and 7th grade enrollees in 2001-02.
 ** Hib vaccine is recommended only for children through age 4 years.
 *** Varicella vaccine is recommended,

but currently not required.

Not for school personnel: Be sure to initial and date any new information that you add to this form after the parent/guardian submits it. Also, Record combination vaccines (e.g./DTP+Hib, Hib+HBV) in each applicable space.

Indicate immunization status and source of above information by choosing one of the following alternatives:

I certify that this student has received all immunizations required by law.

Signature of parent/guardian or physician/public clinic

Date

I certify that this student has received at least one dose of vaccine for diphtheria, tetanus, and pertussis (if age-appropriate), polio, hepatitis B*, measles, mumps, and rubella and will complete his/her diphtheria, tetanus, pertussis, hepatitis B*, and/or polio vaccine series within the next 18 months. The dates for which the remaining doses are to be given are:

Signature of physician or public clinic

Date

LEGAL EXEMPTIONS TO MINNESOTA SCHOOL IMMUNIZATION LAW

- Students 7 years of age or older do not need pertussis vaccine.
- Students 18 years of age or older do not need polio vaccine.
- **Medical exemption:** No student is required to receive and immunization if they have a medical contraindication or laboratory evidence of immunity. To receive a medical exemption, a physician must sign the following statement.

I hereby certify that immunization is contraindicated for medical reasons or that laboratory confirmation of adequate immunity exists for the following immunizations: _____

Signature of physician

Date

- **Conscientious exemption:** No student is required to have an immunization which is contrary to the conscientiously held beliefs of his/her parent or guardian. To receive this exemption, a parent or legal guardian must complete and sign the following statement and have it notarized.

I hereby certify by notarization that immunization of my child is contrary to my conscientiously held beliefs. Indicate vaccine(s):

Signature of parent of legal guardian

Date

Subscribed and sworn to before me this _____ day
of _____ 19 _____.

Signature of notary

Special Exceptions for DTP, Td, and Polio

Children less than 7 years of age: The 5th dose of DtaP/DTP/DT (similarly, the 4th dose of polio vaccine) is not necessary if the 4th DtaP/DTP/DT (3rd dose of polio) was administered after the 4th birthday.

Children 7 years of age and older: A history of 3 doses of DtaP/DTP/DT/Td and 3 doses of polio vaccine meets the minimum requirements of the law.

Students in grades 7-12: A Td booster given at age 11 years or later is not required for students in grades 7-12 whose most recent Td was given after their 7th birthday but before their 11th birthday. Instead, it will be required 10 years after the date of the most recent dose.

Media Release Form

School: _____

Date: _____

Dear Parent or Guardian:

Throughout the school year, the media may visit your school to cover special events. Minneapolis Public Schools may also wish to use your child's photograph, voice or student work for promotional and educational reasons, such as in publications, posters, brochures and newsletters; on the district web site, radio station or Cable TV channel; or at community fairs. Because of state law, a school must obtain permission before your child's photograph or voice can be used by the media or by the district. Please sign and return the bottom part of this page stating whether the district and the media have permission to use your child's photograph, student work or voice for promotional and educational purposes. Thank you for your cooperation.

_____ **I give my permission** for _____
Student's name (please print)

to be filmed/photographed/interviewed by the media during school events and for the district to use my child's photograph/work/voice for promotional and educational purposes.

Parent/Guardian signature

Date

_____ **I do not give my permission** for _____
Student's name (please print)

to be filmed/photographed/interviewed by the media during school events and for the district to use my child's photograph/work/voice for promotional and educational purposes.

Parent/Guardian signature

Date

If you have any questions about this form, please call your school.

Student Data Release Form

For Military Recruitment (11th & 12th Grades)

School: _____

Date: ____/____/____

Dear Parent or Guardian:

Effective August 1, 2001, the Minnesota State Legislature amended the Data Practices Act, which governs the release of student information. The amendment requires schools to release to military recruiting officers upon request the names, addresses, and home telephone numbers of students in grades 11 and 12. The data released to military recruiting officers under this Act: (1) may be used only for the purpose of providing information to students about military service, state and federal veterans' education benefits, and other career and educational opportunities provided by the military; and (2) shall not be further disseminated to any other person except personnel of the recruiting services of the armed forces.

As parent/guardian, you have a right to refuse to release this information by signing and returning this form to the school office. If you do not return this form, information on your student will be released to military officers if requested. Thank you for your cooperation.

I do not give permission for the school to release data on _____
Student's Name (please print)
to military recruiting officers.

Parent/Guardian Signature _____/_____/_____
Date

I give permission for the school to release data on _____
Student's Name (please print)
to military recruiting officers.

Parent/Guardian Signature _____/_____/_____
Date

If you have any questions about this form, please call your school.

Program Policies & General Information

The Minnesota Teen Challenge (MnTC) Life Care program is a Christian residential recovery program. In addition, students attend an on-site Minneapolis Contracted Alternative High School. This school allows students the opportunity to continue their high school education while gaining freedom from addiction and other struggles. It consists of at least 13 months of instruction using a spiritual education model. The program assists individuals in permanently recovering from drug and alcohol abuse and the life-controlling problems associated with it.

MnTC does not discriminate on the basis of race, color, creed, religion, sex, national and ethnic origin, marital status, public assistance, sexual orientation, family status, or disability in the administration of its educational, admission, or program policies or procedures.

Applicants must be committed to complete the entire program to be eligible for admission. Program participants (students) are required to participate in daily devotions, chapel, individual counseling, choir and classes. Daily assignments are a program requirement. Students who do not keep up with their daily assignments and those who fail to demonstrate satisfactory growth may be required to stay in the program beyond the 13 month period.

Each student will have access to our "Student Manual" which covers the policies of the program. MnTC reserves the right to make changes in policy whenever necessary. When a change in policy occurs, students and staff will be notified and the "Student Manual" will be updated to reflect the change. Highlighted below are some basic requirements/guidelines all MnTC students are expected to adhere to while in the program. This is not a complete list of rules, but will serve as a basic example of what will be expected:

Appearance & Dress Code

Personal hygiene must be maintained in a neat and clean manner.

§ Dress requirements for students include three main dress codes:

- **Casual/Class dress:**

Males- collared shirts (no t-shirts), casual slacks, dress jeans or shorts.

Females- shirts, blouses, casual slacks, skirts, dresses, dress jeans or shorts (tank tops may only be worn with a shirt over it).

- **MnTC choir:**

Males- black dress trousers, white button down collared shirt, tie, dark colored shoes and socks.

Females- black skirt, white blouse, black or flesh colored nylons, black shoes.

- **Leisure/recreational dress:**

Shorts (must cover $\frac{3}{4}$ of thigh), t-shirts, sweat suits, swim trunks and jeans. *Females*: one piece bathing suit for swimming.

§ Students may not wear jewelry in any body piercing, with the exception of ears for female students only.

§ Hairstyles that bring unusual attention are not allowed. Hair color must be of a normal color.

Approved Personal Belongings

The following is a list of items students should bring if they have them. If they don't have them and don't have the means to purchase them, many of them may be provided at no cost.

*** Please note due to space limitations students may only bring the equivalent of two suitcases full of belongings. Belongings must be brought into the program in plastic garbage bags; suitcases are NOT allowed.**

§ Clothing: See dress code above. Winter/rain/light jacket, gloves, underwear, socks etc.

§ Toiletries: soap, comb, toothbrush/paste, shampoo, deodorant, razor/shaving cream, blow dryer. *Females*: makeup, sanitary items, etc.

§ Linens: blanket, pillow/case, twin sheets, towel/washcloth.

§ Medications: 30 day supply of all prescription medications (excluding prescribed narcotics), non-prescription medications.

§ Misc.: Bible, envelopes/stamps, umbrella, family picture (8x10 max), camera/film.

Prohibited Personal Belongings

Storage space for personal items is limited. Due to this students will only be allowed to bring the equivalent of two suitcases worth of belongings; belongings must be brought in **plastic garbage bags** as suitcases are not allowed. In addition to the two suitcase limit students may not bring any of the following items. If they do, they will be required to immediately dispose of them or mail them home at their own expense.

- | | |
|--|---|
| § Expensive jewelry/clothing or other valuable items | § Musical instruments |
| § Items of sentimental value | § Drugs or drug paraphernalia, alcohol & tobacco |
| § Electronics: Cassette players/cassettes, VCR's/VHS tapes, DVD players/DVD's, headsets, video games, radios, TV's, computers, cell phones | § Recreation equipment/games including: cards/dice |
| § Personal vehicles | § Tools of any kind |
| § Aerosols of any kind | § Weapons of any kind |
| | § Literature including: books, magazines, newspaper |

Employment/Work Study

Due to the nature and schedule of our program, students are not able to seek employment or be employed throughout the duration of their treatment.

- § Students are required to participate in work-study assignments. All students will be required to participate in general housekeeping and clean-up assignments.
- § Students will also have the option of voluntarily participating in other work-study assignments that will allow them to learn new or refine existing skills.

Mail/Visitation

The first two weeks of the program are considered the orientation period. During this time, mail, phone, and visitation communication is limited to parents and siblings.

- § Students may receive visits from their personal physician, religious advisor, county case manager, attorney, and parole/probation officer at any reasonable hour.
- § After the orientation period, correspondence will be limited to those who have been approved. Mail from those who have not been approved will be returned to the sender.
- § Students may temporarily lose phone, mail, or visitor privileges if they are caught manipulating the system.

Medical/Dental Care & Prescription Medications

Students are responsible for all their health care expenses. Students who do not have medical and/or dental insurance will be provided help in signing up for Minnesota Health Care and General Assistance. Since this is a county/state program MnTC cannot guarantee that any student will be approved for medical and/or dental benefits.

- § Students are required to obtain a summary of each medical and dental visit prior to leaving the place of treatment and must provide the information to their staff immediately upon return to MnTC.
- § Students should bring enough prescription medication to last at least 30 days, and bring it in their original containers bearing appropriate labels.
- § Students are strongly encouraged to take prescription medication exactly the way their doctor prescribes it. If subsequent medical treatment or behavioral issues arise as a result of a refusal to take prescribed medications, the student may be discharged from the program.
- § While in MnTC students are not permitted to take narcotics and certain other medications. Please see the Prohibited Medications document in this packet.

Possession/Use of Drugs, Alcohol & Tobacco

Possession and/or use of drugs, alcohol and tobacco are prohibited while enrolled in our program.

- § Students may be given drug and/or alcohol tests at any time without prior notice or approval. Students who test positive for drugs and/or alcohol use while in our program will face disciplinary action and possible discharge from MnTC.
- § Students, their rooms, and their personal property may be searched at any time without prior notice or approval.

Daily Schedule

Students are required to participate in all daily scheduled programming and activities, with the exception of optional recreational activities. Although not every week day is scheduled the same, and schedules vary from program to program, students can expect a typical weekday at MnTC to be as follows:

6:00am	Wake-up
6:00am-6:30am	Showers/Morning Chores
6:30am-7:30am	Breakfast/Clean-up
8:00am-9:00am	Devotions/Chapel
9:00am-11:00am	Lecture & Individual Study
11:30am-12:00pm	Lunch
12:00pm-5:00pm	High School
5:00pm-5:30pm	Dinner/Clean-up
6:00pm-9:00pm	Study/Free Time/Recreation
10:00pm	Lights out

- § In addition to this schedule each Wednesday students are expected to participate in group choir rehearsal and evening church groups at different churches in the local community.
- § Saturday's are less structured and include time in the afternoon for visits from approved family and friends as well as passes for upper level students.

Program Outline

The MnTC program consists of four levels. Each level focuses on the recovery and spiritual and emotional wellness of the student. In the paragraphs that follow is a general outline and approximate timeline of each level.

Level One (approximately 8 weeks)

In level one students attend classes that promote life recovery in the areas of: chemical dependency, anger management, personal relationships, family dynamics, depression, self-acceptance, and maintaining a chemical-free lifestyle.

Level Two (approximately 18 weeks)

In level two students attend a series of classes designed to assist in the development of personal character and in the facilitation of healthy relationships with others. Students also work independently on materials focusing on their specific personal and family issues. They continue receiving these materials throughout the remainder of the program as they address each major issue in their lives.

Level Three (approximately 12 weeks)

In level three students learn how to deal with the pain and emotional suffering associated with their current and past issues. Students attend classes designed to provide healing for damaged emotions and confront the issues that have left them emotionally scarred. Family therapy may be offered to students when they enter this level and may continue through level four.

Level Four (approximately 12 weeks)

Throughout level four students focus on transitioning back into their local community. They receive classroom instruction on marriage and home, financial management, how to be good citizens and solving life's problems. Level four students also receive assistance with obtaining affordable housing, finding adequate employment, and connecting with a mentor in the local community

Room and Board Fee Information

Costs for the Adolescent program are \$1350 per month. In some cases applicants may be eligible for financial assistance in the form of scholarships. Please note the number of scholarships is limited. Please see your admissions representative for more information about scholarships.

Application Fee:

A \$100 non-refundable application fee is required for all adolescent students at the time of admission. This fee is assessed to help cover the costs associated with processing the application and admitting the student into the program.

Damage Deposit:

A \$100 damage deposit is required for all adolescent students at the time of admission. Money from this deposit will be used to repair or replace damaged property caused by the student. Students are required to replace money used from the damage deposit so that a \$100 deposit is maintained at all times. Upon discharge, the damage deposit minus any damage expenses will be refunded.

Return Transportation Deposit:

A \$200 return transportation deposit is required for all adolescent applicants who reside outside of Minnesota. This deposit must be paid when the student is admitted into the program. Money from this deposit will be used to provide return transportation home if required. Upon discharge, the transportation deposit minus any transportation expenses will be refunded.

Room and Board Fee:

Room and board fees are pro-rated so that students are charged only for the days they are enrolled in the program. Students are considered enrolled in the program even though they may be temporarily away from our facility while on pass or holiday break. Students will be charged for the day they are admitted into the program but will not be charged for the day they are discharged.

Students are required to pay the current month's pro-rated room and board fee at the time of admission. If the admission date occurs after the 15th of the month, the next month's room and board fee is also due. Each month thereafter, the room and board fee is due on the 1st day of each month. Upon discharge, any room and board fees collected will be refunded minus the amount for days spent in the program. A 30-day written notice will be given prior to any room and board rate increase.

Late Fees:

If the room and board fee is not received by the 5th of the month, a late fee of \$25 will be assessed.

Reinstatement Fee: Students who leave the program and are allowed to re-enter the program within 30 days are required to pay a \$100 reinstatement fee.

Break Policy

Minnesota Teen Challenge takes three short breaks each year. These breaks occur over the Fourth of July, Thanksgiving, and Christmas. Normal student activities do not occur during scheduled breaks. Minnesota Teen Challenge is not liable for the safety of students who are away from our facility on break.

Eligibility

Students may go home during these breaks only if all of the following conditions are met:

- § They must be in our program at least 90 consecutive days prior to the start of the break.
- § They must have the approval of their program dean.
- § If on parole/probation, they must have written permission from their probation officer.

Transportation & Safety

Minnesota Teen Challenge does not provide transportation for students who are going away on break. This includes transportation to/from airports, train stations, bus stations, or any other location. MnTC is not liable for the safety of students when they are away from our facility.

Students Remaining At Teen Challenge During Break

Students are not required to return home during scheduled breaks. Recreation and other activities will be scheduled for students who remain in our facility during these breaks. Family and friends desiring to visit students during scheduled breaks must contact the program dean to arrange dates and times of visitation.

Break Schedule

A schedule of when students may depart and when they must return during each break is listed below and is also posted on the bulletin board in the student's living facility. Students who do not return from break on time may be discharged, set back in the program, and/or lose future opportunities to go home during scheduled breaks.

Fourth of July 2009: Students may not leave our facility prior to 1:00 pm on Thursday July 2, 2009 and must return to our facility no later than 6:00 pm on Sunday July 5, 2009.

Thanksgiving 2009: Students may not leave our facility prior to 1:00 pm on Wednesday, November 25, 2009 and must return to our facility no later than 6:00 pm on Saturday, November 28, 2009.

Christmas 2009: Students may not leave our facility prior to 1:00 pm on Wednesday, December 23, 2009 and must return to our facility no later than 6:00 pm on Saturday, December 26, 2009.

Prohibited Medications

Due to their interference with the recovery process, Minnesota Teen Challenge prohibits the use of all addictive medications and those medications that have the potential for abuse and dependence. Prospective students that are currently taking any of the listed medications need to check with their health care provider, prior to or soon after admission, to determine if an appropriate alternate medication is available. Prospective students are strongly encouraged NOT to discontinue use of medication without first checking with the prescribing doctor or if admitted to MnTC, talking with the onsite nurse. In the rare circumstance that an alternate is not available, Minnesota Teen Challenge is not an appropriate treatment option and a referral list of other treatment programs in the area will be provided. If an appropriate alternate medication is not available, the student will be discharged for medical reasons and a referral to another program will be provided.

Examples of addictive medications include but are not limited to the following:

All Narcotic pain relievers and pain relievers with potential for dependence and abuse

Vicodin-(hydrocodone with acetaminophen)
OxyContin-(oxycodone)
Percocet-(oxycodone with acetaminophen)
Dilaudid
Morphine
Tramadol-Ultram
Darvocet-Darvocet N (propoxyphene)
Tylenol with Codeine (acetaminophen with codeine)
Cough medicine containing codeine
Demerol (meperidine)

***Due to the highly addictive nature of narcotic pain relievers and their potential to undermine the program participants' recovery efforts and mindset, prescriptions written for these medications, following a surgery or injury, are not permitted while in MnTC. MnTC nursing staff will work with students and their health care providers to find other non-narcotic pain relievers that are permitted.**

All medications used for the treatment of opiate dependence, e.g. Methadone, Suboxone, Subutex, Naltrexone

All barbiturates, including those combined with acetaminophen, caffeine or aspirin e.g. Fiorocet, Fiorinal

All Benzodiazepines

Xanax (alprazolam)	Dalmane (flurazepam)	Restoril (temazepam)
Klonopin (clonazepam)	Halcion (triazolam)	Serax (oxazepam)
Valium (diazepam)	Tranxene (chlorazepate)	Ativan (lorazepam)

Sleep Aids Ambien and Ambien CR (zolpidem), Sonata (zalepon)

Muscle Relaxants SOMA (carisoprodol)

All stimulant medications used to treat Attention Deficit Disorder & Attention Deficit/Hyperactivity Disorder

Adderall (amphetamine mixed salts)	Methylin (methylphenidate HCL)
Adderall XR	Daytrana (methylphenidate HCL)
Concerta (methylphenidate HCL)	Metadate (methylphenidate HCL)
Ritalin (methylphenidate HCL)	Dexedrine (dextroamphetamine sulfate)
Ritalin SR	Focalin (dexmethylphenidate HCL)
Vyvanse (lisdexamfetamine)	

Any prescribed or over the counter medications used specifically for weight loss.

Smoking Cessation medication – Chantix (vareniclin)